

Fig. 1



Fig. 2

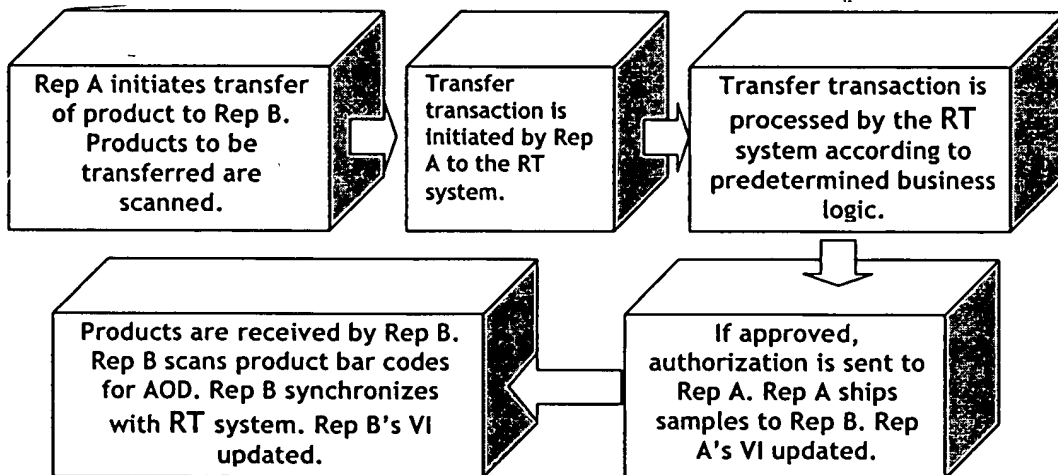


Fig. 3

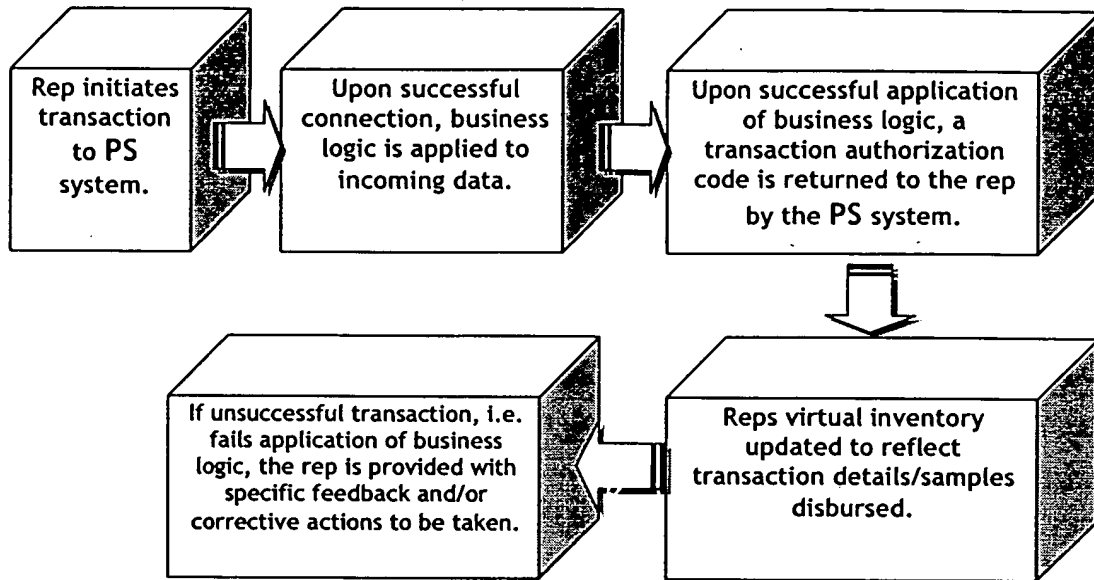


Fig. 4

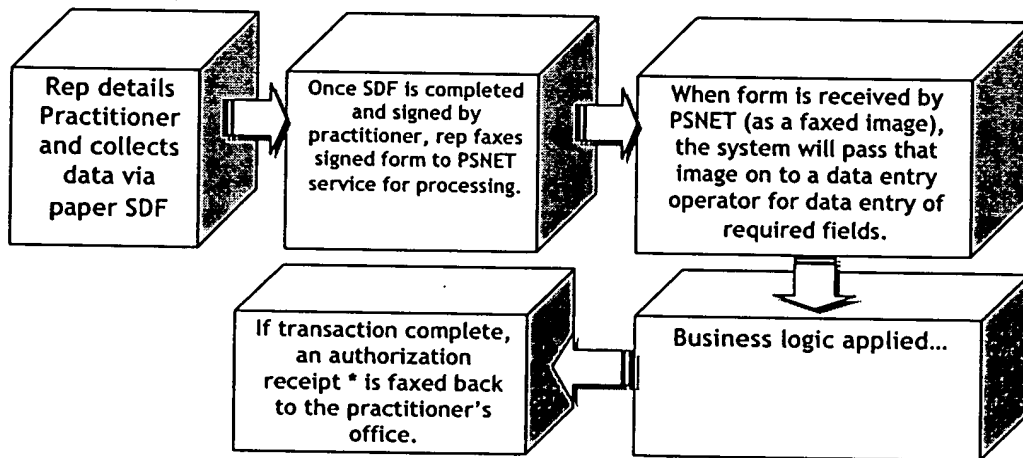


Fig. 5

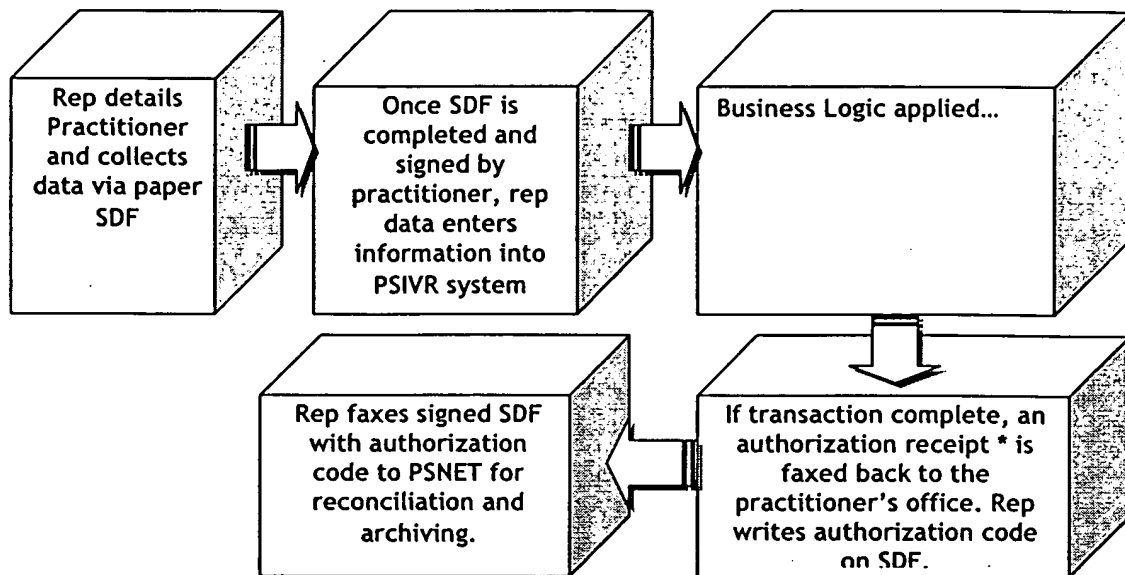


Fig. 6

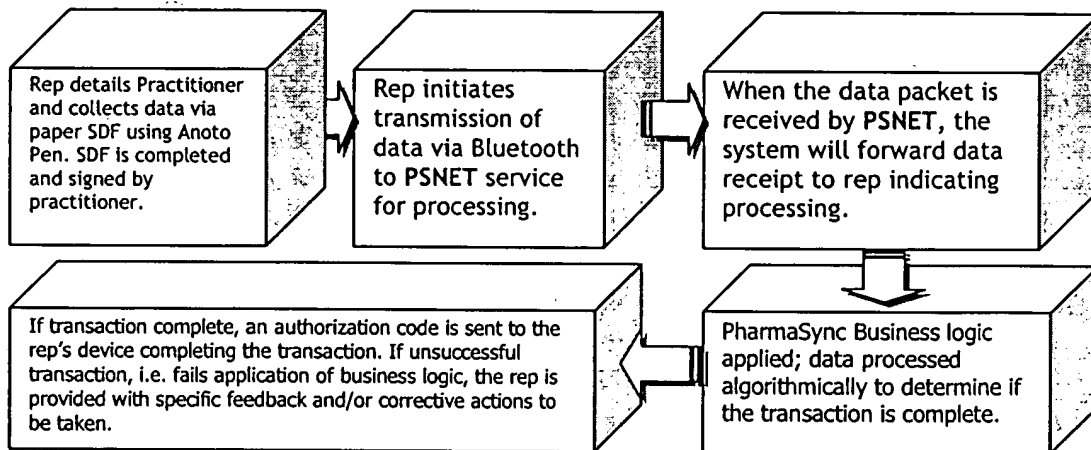


Fig. 7

Pharmaceuticals

Professional designation (please fill in circle)

☐ MD ☐ DO ☐ PA ☐ NP

Practitioner's Name: _____

Street Address

City

State:

22

State License #

Rep's Employee #

Sample Disbursement Form

All information on this form must be completed to be in compliance with federal regulations

Territory Number

Call Date

Rep's Name

Document Number

R1234567

I requested and received the samples listed below for the medical needs of my patients. I certify that I am a licensed practitioner in the state shown in my address.

X

PRACTITIONER'S SIGNATURE & DATE

[illegible]

Fig. 8

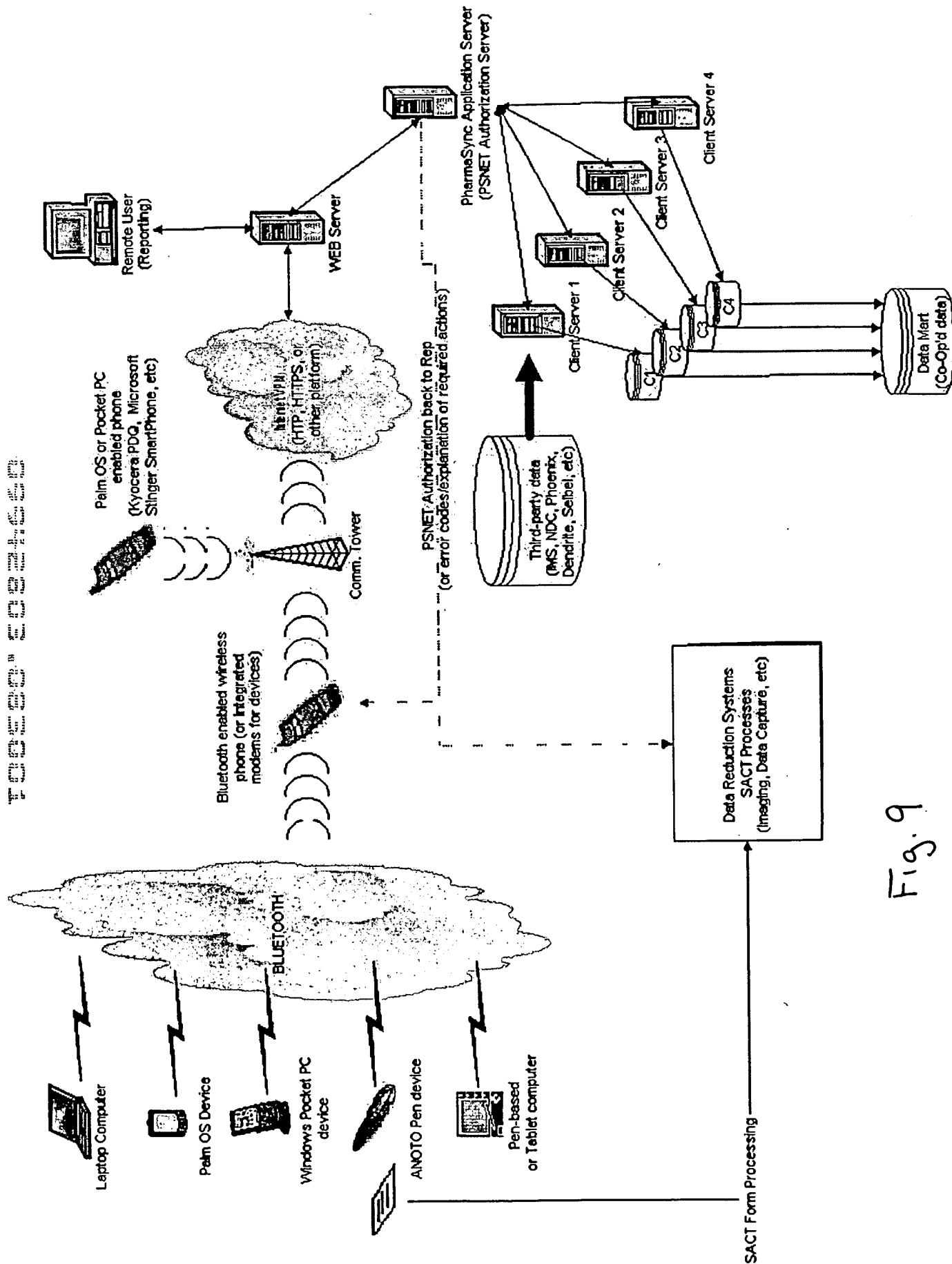


Fig. 9